FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021550

Facility Name: BOURBONNAIS TERRACE

Address: 133 MOHAWK DR. (Number) BOURBONNAIS (City) 60914 (Zip Code)

County: KANKAKEE

Telephone Number: (815) 937-4790 **Fax #** (815) 937-9321

IDPA ID Number: 36-2821184

Date of Initial License for Current Owners: 01/01/78

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,600	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,502	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	72,102	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	67,731	854		68,585	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	67,731	854		68,585	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.12%

D. How many bed-hold days during this year were paid by Public Aid?
956 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	256,842	20,363	9,540	286,745		286,745		286,745			1
2	Food Purchase		253,381		253,381		253,381	(1,133)	252,248			2
3	Housekeeping	220,107	19,743		239,850		239,850		239,850			3
4	Laundry	70,203	14,153	3,888	88,244		88,244	190	88,434			4
5	Heat and Other Utilities			133,748	133,748		133,748	489	134,237			5
6	Maintenance	91,297	27,441	31,158	149,896		149,896	4,273	154,169			6
7	Other (specify):*			9,538	9,538		9,538	85	9,623			7
8	**TOTAL General Services**	638,449	335,081	187,872	1,161,402		1,161,402	3,904	1,165,306			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	1,670,164	34,070	15,291	1,719,525		1,719,525		1,719,525			10
10a	Therapy	57,524		4,186	61,710		61,710		61,710			10a
11	Activities	92,725	4,870	1,013	98,608		98,608		98,608			11
12	Social Services	146,742		3,132	149,874		149,874		149,874			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,967,155	38,940	29,122	2,035,217		2,035,217		2,035,217			16
	C. General Administration											
17	Administrative	71,706		556,541	628,247		628,247	(534,776)	93,471			17
18	Directors Fees											18
19	Professional Services			42,739	42,739		42,739	7,390	50,129			19
20	Dues, Fees, Subscriptions & Promotions			18,462	18,462		18,462	(2,145)	16,317			20
21	Clerical & General Office Expenses	113,875	23,929	118,578	256,382		256,382	(71,860)	184,522			21
22	Employee Benefits & Payroll Taxes			433,215	433,215		433,215		433,215			22
23	Inservice Training & Education							77	77			23
24	Travel and Seminar			2,580	2,580		2,580		2,580			24
25	Other Admin. Staff Transportation			9,068	9,068		9,068	770	9,838			25
26	Insurance-Prop.Liab.Malpractice			97,207	97,207		97,207	609	97,816			26
27	Other (specify):*							5,917	5,917			27
28	**TOTAL General Administration**	185,581	23,929	1,278,390	1,487,900		1,487,900	(594,018)	893,882			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,791,185	397,950	1,495,384	4,684,519		4,684,519	(590,114)	4,094,405			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: BOURBONNAIS TERRACE **#0021550** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,540	
	REPAIRS & MAINTENANCE		0	
			0	9,540
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,888	
			0	3,888
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		16,387	
	ELECTRICITY		64,562	
	WATER		45,727	
	CABLE TV - LOBBY		7,072	
			0	133,748
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,070	
	PAINTING & DECORATING		3,258	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		20,458	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		58	
	EXTERMINATING SERVICE		1,958	
	FIRE SERVICE		1,356	
			0	
			0	
			0	31,158
7	**OTHER**			
	SCAVENGER		8,871	
	SECURITY SERVICE		667	9,538
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,500	5,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	144	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	5,790	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	5,907	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,450	
			0	15,291
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	3,225	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	961	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	4,186
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,013	
			0	1,013
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	3,132	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	3,132
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BOURBONNAIS TERRACE **#0021550** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	556,541	556,541
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	15,926	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	26,813	
			0	42,739
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	353	
	EMPLOYEE WANT ADS	XIX F	1,630	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	9,410	
	LICENSES & PERMITS	XIX F	4,200	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,369	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,000	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	18,462
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,483	
	EQUIPMENT REPAIR & MAINTENANCE		705	
	OUTSIDE CLERICAL SERVICES		102,098	
	PENALTIES / OVERDRAFT CHARGES	VI 18	52	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		10,760	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		3,480	118,578

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	212,103	
	UNEMPLOYMENT COMPENSATION	XIX D	35,666	
	WORKERS COMPENSATION INSURANCI	XIX D	75,560	
	HOSPITALIZATION INSURANCE	XIX D	109,176	
	EMPLOYEE BENEFITS - OTHER	XIX D	710	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	433,215
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	2,580	
	TRAVEL	XIX G	0	
			0	
			0	2,580
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,068	9,068
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		97,207	97,207
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,495,384

Facility Name & ID Number BOURBONNAIS TERRACE #0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			56,077	56,077		56,077	5,681	61,758			30
31	Amortization of Pre-Op. & Org.			4,195	4,195		4,195		4,195			31
32	Interest			212,521	212,521		212,521	(78,252)	134,269			32
33	Real Estate Taxes			65,021	65,021		65,021	2,100	67,121			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			30,169	30,169		30,169	5,522	35,691			35
36	Other (specify):* IME rent, amort software			22,603	22,603		22,603	(15,366)	7,237			36
37	**TOTAL Ownership**			390,586	390,586		390,586	(80,315)	310,271			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,154	108,154		108,154		108,154			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			108,154	108,154		108,154		108,154			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,791,185	397,950	1,994,124	5,183,259		5,183,259	(670,429)	4,512,830			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,902	30		9
10	Interest and Other Investment Income	(80,202)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,133)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(52)	21		18
19	Entertainment		20		19
20	Contributions	(1,500)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(353)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,369)	20		28
29	Other-Attach Schedule	(10,155)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (90,862)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(579,567)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (579,567)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (670,429)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BOURBONNAIS TERRACE

ID# 0021550

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 808	6	1
2	STAFF DEVELOPMENT	(3,480)	21	2
3	BANK CHARGES	(1,483)	21	3
4	PHILIP ESFORMES - MANAGEMENT FEES	(6,000)	17	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,155)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,133)	0	0	0	0	0	0	0	0	0	0	(1,133)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	190	0	0	0	0	0	0	0	0	190	4
5	Heat and Other Utilities	0	0	0	489	0	0	0	0	0	0	0	489	5
6	Maintenance	808	0	2,227	1,238	0	0	0	0	0	0	0	4,273	6
7	Other (specify):*	0	0	33	52	0	0	0	0	0	0	0	85	7
8	**TOTAL General Services**	(325)	0	2,450	1,779	0	0	0	0	0	0	0	3,904	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(6,000)	(536,144)	7,368	0	0	0	0	0	0	0	0	(534,776)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	174	7,138	78	0	0	0	0	0	0	0	7,390	19
20	Fees, Subscriptions & Promotions	(3,222)	0	1,077	0	0	0	0	0	0	0	0	(2,145)	20
21	Clerical & General Office Expenses	(5,015)	8,397	(75,458)	216	0	0	0	0	0	0	0	(71,860)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	77	0	0	0	0	0	0	0	0	77	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	242	528	0	0	0	0	0	0	0	0	770	25
26	Insurance-Prop.Liab.Malpractice	0	0	352	257	0	0	0	0	0	0	0	609	26
27	Other (specify):*	0	1,157	4,760	0	0	0	0	0	0	0	0	5,917	27
28	**TOTAL General Administration**	(14,237)	(526,174)	(54,158)	551	0	0	0	0	0	0	0	(594,018)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,562)	(526,174)	(51,708)	2,330	0	0	0	0	0	0	0	(590,114)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,902	0	281	1,498	0	0	0	0	0	0	0	5,681	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(80,202)	0	0	1,950	0	0	0	0	0	0	0	(78,252)	32
33	Real Estate Taxes	0	0	0	2,100	0	0	0	0	0	0	0	2,100	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	700	4,674	148	0	0	0	0	0	0	0	5,522	35
36	Other (specify):*	0	0	0	(15,366)	0	0	0	0	0	0	0	(15,366)	36
37	**TOTAL Ownership**	(76,300)	700	4,955	(9,670)	0	0	0	0	0	0	0	(80,315)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(90,862)	(525,474)	(46,753)	(7,340)	0	0	0	0	0	0	0	(670,429)	45

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				EKS MGMT.	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT. CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 550,541	EMI ENTERPRISES, INC.		$	$ (550,541)	1
2	V								2
3	V								3
4	V	17	OFFICERS SALARY				14,397	14,397	4
5	V	19	ACCOUNTING FEES				174	174	5
6	V	21	OFFICE EXPENSE				8,397	8,397	6
7	V	25	TRANSPORTATION				242	242	7
8	V	26	INSURANCE						8
9	V	27	EMPLOYEE BENEFITS				1,157	1,157	9
10	V								10
11	V	35	AUTO LEASE				700	700	11
12	V								12
13	V								13
14	Total			$ 550,541			$ 25,067	$ * (525,474)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING FEES	$ 102,000	EKS MANAGEMENT, INC.		$	$ (102,000)	15
16	V								16
17	V	4	HOUSEKEEPING SALARIES				190	190	17
18	V	6	PAINTING SALARIES				2,227	2,227	18
19	V	7	SCAVENGER				33	33	19
20	V	17	CFO SALARY				7,368	7,368	20
21	V	19	PROFESSIONAL FEES				7,138	7,138	21
22	V	20	WANTS AD				1,077	1,077	22
23	V	21	OFFICE EXPENSE				26,542	26,542	23
24	V	23	SEMINARS				77	77	24
25	V	24	IN-STATE LODGING/MEALS						25
26	V	25	TRANSPORTATION				528	528	26
27	V	26	INSURANCE				352	352	27
28	V	27	EMPLOYEE BENEFITS				4,760	4,760	28
29	V	30	DEPRECIATION				281	281	29
30	V	35	EQUIPMENT RENTAL				4,674	4,674	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 102,000			$ 55,247	$ * (46,753)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 15,366	IME REALTY CORP.		$	$ (15,366)	15
16	V								16
17	V	5	UTILITIES				489	489	17
18	V	6	REPAIRS & MAINTENACE				1,238	1,238	18
19	V	7	ALARM SERVICE				52	52	19
20	V	19	PROFESSIONAL FEES				78	78	20
21	V	21	OFFICE EXPENSE				216	216	21
22	V	26	INSURANCE				257	257	22
23	V	30	DEPRECIATION				1,498	1,498	23
24	V	32	INTEREST				1,950	1,950	24
25	V	33	RE TAX				2,100	2,100	25
26	V	35	STORAGE FEES				148	148	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,366			$ 8,026	$ * (7,340)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	GEN. PARTNER	ADMINISTSRATION		SEE ATTACHED SCHEDULE			SALARY	$ 14,397	17-8	1
2	AVRUM WEINFELD	CFO						SALARY	7,368	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 21,765		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		OFFICERS SALARY	PATIENT DAYS	881,303	14	$ 185,000	$ 185,000	68,585	$ 14,397	1
2		ACCOUNTING FEES	PATIENT DAYS	881,303	14	2,230		68,585	174	2
3		OFFICE EXPENSE	PATIENT DAYS	881,303	14	107,899	87,197	68,585	8,397	3
4		TRANSPORTATION	PATIENT DAYS	881,303	14	3,109		68,585	242	4
5		INSURANCE	PATIENT DAYS	881,303	14				0	5
6		EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	14,871		68,585	1,157	6
7		AUTO LEASE	PATIENT DAYS	881,303	14	8,991		68,585	700	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 322,100	$ 272,197		$ 25,067	25

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	881,303	14	$ 2,437	$ 2,437	68,585	$ 190	1
2	6	PAINTING / DECORATING	PATIENT DAYS	881,303	14	28,615	28,615	68,585	2,227	2
3	7	SCAVENGER	PATIENT DAYS	881,303	14	429		68,585	33	3
4	17	CFO SALARY	PATIENT DAYS	881,303	14	94,671	94,671	68,585	7,368	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	881,303	14	91,723		68,585	7,138	5
6	20	WANTS AD	PATIENT DAYS	881,303	14	13,841		68,585	1,077	6
7	21	OFFICE EXPENSE	PATIENT DAYS	881,303	14	341,059	251,740	68,585	26,542	7
8	23	SEMINARS	PATIENT DAYS	881,303	14	984		68,585	77	8
9	25	TRANSPORTATION	PATIENT DAYS	881,303	14	6,783		68,585	528	9
10	26	INSURANCE	PATIENT DAYS	881,303	14	4,521		68,585	352	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	61,166		68,585	4,760	11
12	30	DEPRECIATION	PATIENT DAYS	881,303	14	3,617		68,585	281	12
13	35	EQUIPMENT RENT	PATIENT DAYS	881,303	14	60,061		68,585	4,674	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 709,907	$ 377,463		$ 55,247	25

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	312,433	14	$ 9,942	$	15,366	$ 489	1
2	6	REPAIRS & MAINTENANCE	INCOME	312,433	14	25,152		15,366	1,238	2
3	7	ALARM SERVICE	INCOME	312,433	14	1,056		15,366	52	3
4	19	PROFESSIONAL FEES	INCOME	312,433	14	1,575		15,366	78	4
5	21	OFFICE EXPENSE	INCOME	312,433	14	4,388		15,366	216	5
6	26	INSURANCE	INCOME	312,433	14	5,225		15,366	257	6
7	30	DEPRECIATION	INCOME	312,433	14	30,446		15,366	1,498	7
8	32	INTEREST	INCOME	312,433	14	39,619		15,366	1,950	8
9	33	RE TAX	INCOME	312,433	14	42,669		15,366	2,100	9
10	35	STORAGE FEES	INCOME	312,433	14	3,011		15,366	148	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 163,083	$		$ 8,026	25

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	LASALLE NAT;L BANK		X	MORTGAGE	$27,208.00	11/01/01	$ 4,004,402	$ 3,668,696	10/31/26		$ 211,217	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE NAT'L BANK		X	LINE OF CREDIT	INTEREST	REVOLV		225,000	REVOLV	PRIME +	1,304	6
7												7
8		X		RELATED PARTY							1,950	8
9	TOTAL Facility Related				$27,208.00		$ 4,004,402	$ 3,893,696			$ 214,471	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,004,402	$ 3,893,696			$ 214,471	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 68,333	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 66,677	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,656)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 66,677	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 65,021	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	60,602	8
	2000	68,983	9
	2001	68,535	10
	2002	68,333	11
	2003	66,677	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BOURBONNAIS TERRACE COUNTY KANKAKEE

FACILITY IDPH LICENSE NUMBER 0021550

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-09-17-300-020	NURSING HOME	$ 66,676.82	$ 66,676.82
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 66,676.82	$ 66,676.82

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,232 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	165,000		$ 187,600	1
2					2
3	TOTALS	165,000		$ 187,600	3

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	197		1975	1975	$ 1,838,000	$		$	$	$ 1,838,000	4
5	RELATED										5
6	PARTY					1,439		1,439			6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1981	54,211		10			54,211	9
10	LEASEHOLD IMPROVEMENT			1982	17,608		10			17,608	10
11	ROOFING			1983	1,875		15			1,875	11
12	ROOFING			1984	6,215		18			6,215	12
13	IMPROVEMENTS			1987	21,900	695	31.5	695		12,510	13
14	STONE DRIVE			1990	7,800	248	31.5	248		3,565	14
15	IMPROVEMENTS			1991	26,075	828	31.5	828		10,936	15
16	IMPROVEMENTS			1992	38,485	1,222	31.5	1,222		15,275	16
17	ROOFING			1993	21,500	551	39	551		7,671	17
18	GUTTERS			1994	7,248	186	39	186		1,976	18
19	CONCRETE			1994	7,967	204	39	204		2,117	19
20	FLOOR			1995	766	20	39	20		199	20
21	TILES			1995	1,580	40	39	40		400	21
22	FLOOR			1995	934	24	39	24		237	22
23	CONCRETE			1995	2,500	64	39	64		584	23
24	TILES			1996	5,820	149	39	149		1,285	24
25	SEWERS			1996	10,000	256	39	256		2,187	25
26	TILES			1996	16,056	412	39	412		3,519	26
27	ROOF			1996	21,650	555	39	555		4,695	27
28	CONCRETE			1996	7,949	204	39	204		1,709	28
29	SCREENS			1996	1,424	37	39	37		307	29
30	DISPOSER BASE UNIT			1996	732	19	39	19		153	30
31	FLOORING IMPROVEMENTS			1997	16,979	435	39	435		3,281	31
32	WINDOWS			1998	1,680	43	39	43		301	32
33	INSTALL NEW SIGN			1998	2,643	68	39	68		411	33
34	NURSES STATION			1999	3,520	90	39	90		522	34
35	KITCHEN A/C UNIT			1999	6,696	172	39	172		939	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FURNISHING - CARPET / WALLPAPER	1999	$ 16,384	$ 1,461	7	$	$ (1,461)	$ 16,384	37
38	FENCE	2000	2,800	187	15	187		896	38
39	DUCT WORK	2000	14,000	509	27.5	509		2,100	39
40	IN WALLS HEATERS	2000	12,407	451	27.5	451		2,236	40
41	IN WALLS HEATERS	2000	4,378	159	27.5	159		383	41
42	FURNISHING	2000	23,248	2,076	7	3,321	1,245	16,606	42
43	DOORS	2000	881	32	27.5	32		159	43
44	BATHROOM	2001	2,782	101	27.5	101		358	44
45	HVAC UNITS	2001	15,737	572	27.5	572		2,026	45
46	BUILT IN CLOSETS	2001	60,000	2,182	27.5	2,182		7,728	46
47	WINDOWS	2001	2,995	109	27.5	109		436	47
48	FURNISHINGS	2001	5,208	600	5	1,042	442	4,167	48
49	ROOF	2002	52,300	1,902	27.5	1,902		5,151	49
50	HEATING & AIR CON	2002	27,923	1,015	27.5	1,015		2,580	50
51	HEAT/COOL WALL UNITS	2003	2,764	101	27.5	101		181	51
52	VINYL FLOORING	2003	10,087	367	27.5	367		658	52
53	NURSES STATION	2003	27,711	1,008	27.5	1,008		1,218	53
54	ROOF	2003	27,000	982	27.5	982		1,187	54
55	DOOR ALARM	2003	1,412	51	27.5	51		53	55
56	FURNISHINGS - DRAPES & CARPETS	2003	11,358	2,544	5	2,272	(272)	4,544	56
57	CUBICLE CURTAINS	2004	16,747	10,049	5	3,349	(6,700)	3,349	57
58	SMOKE DETECTORS	2004	15,656	308	27.5	308		308	58
59	DOORS	2004	9,141	180	27.5	180		180	59
60	FLOOR TILE	2004	3,491	16	27.5	16		16	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,516,223	$ 34,923		$ 28,177	$ (6,746)	$ 2,065,592	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 336,305	$ 17,265	$ 32,797	$ 15,532		$ 229,853	71
72	Current Year Purchases	8,879	5,328	444	(4,884)		444	72
73	Fully Depreciated Assets	406,349					406,349	73
74	RELATED PARTIES		340	340				74
75	TOTALS	$ 751,533	$ 22,933	$ 33,581	$ 10,648		$ 636,646	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,455,356	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 57,856	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 61,758	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,902	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,702,238	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		197		$			3
4	Additions							4
5								5
6								6
7	TOTAL		197		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 22,015 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT/ACTIVITIES	2003 FORD E350 WAGON	$ 625.70	$ 7,508	17
18	MAINT.	2003 CHEVY ASTRO VAN	645.50	646	18
19					19
20					20
21	TOTAL		$ #######	$ 8,154	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 105,688	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (70,000))	1,307,830		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	119,782		6
7	Other Prepaid Expenses	10,362		7
8	Accounts Receivable (owners or related parties)	1,760,693		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,304,355	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	187,600		13
14	Buildings, at Historical Cost	1,838,000		14
15	Leasehold Improvements, at Historical Cost	605,278		15
16	Equipment, at Historical Cost	835,333		16
17	Accumulated Depreciation (book methods)	(2,799,887)		17
18	Deferred Charges	35,369		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): AMORT OF DEF LOANS	(20,521)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 681,172	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,985,527	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 148,829	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	225,000		29
30	Accrued Salaries Payable	94,439		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,061		31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,677		32
33	Accrued Interest Payable	13,894		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTIES	30,523		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 616,423	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,668,696		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,668,696	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,285,119	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (299,592)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,985,527	$	48

*(See instructions.)

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (329,177)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (329,177)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	568,960	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(539,375)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 29,585	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (299,592)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,688,564	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,688,564	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	80,202	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 80,202	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,768,766	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,161,402	31
32	Health Care	2,035,217	32
33	General Administration	1,487,900	33
	B. Capital Expense		
34	Ownership	390,586	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	108,154	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,183,259	40
41	**Income before Income Taxes (line 30 minus line 40)****	585,507	41
42	**Income Taxes**	(16,547)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 568,960	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,083	2,123	$ 61,350	$ 28.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,347	4,647	107,294	23.09	3
4	Licensed Practical Nurses	21,468	24,308	468,132	19.26	4
5	Nurse Aides & Orderlies	69,509	78,414	909,625	11.60	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,884	4,256	57,524	13.52	8
9	Activity Director					9
10	Activity Assistants	8,744	9,990	92,725	9.28	10
11	Social Service Workers	12,285	13,685	146,742	10.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,983	22,259	256,842	11.54	15
16	Dishwashers					16
17	Maintenance Workers	7,217	7,527	91,297	12.13	17
18	Housekeepers	20,681	22,839	220,107	9.64	18
19	Laundry	5,294	5,868	70,203	11.96	19
20	Administrator	1,994	2,235	71,706	32.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,411	11,195	113,875	10.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: nrsg clerical	6,651	7,358	123,763	16.82	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	194,551	216,704	$ 2,791,185 *	$ 12.88	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly fee	$ 9,540	1-3	35
36	Medical Director	monthly fee	5,500	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fee	5,907	10-3	39
40	Physical Therapy Consultant	62	3,225	10a-3	40
41	Occupational Therapy Consultant	19	961	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	19	1,013	11-3	44
45	Social Service Consultant	58	3,132	12-3	45
46	Other(specify) DENTAL	monthly fee	3,450	10-3	46
47	PSYCHO SOCIAL	145	5,790	10-3	47
48					48
49	TOTAL (lines 35 - 48)	303	$ 38,518		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses	8	144	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	8	$ 144		53

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DEBRA WOOD	ADMIN	0	$ 71,706
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 71,706

B. Administrative - Other

Description	Amount
EMI ENTERPRISES MANAGEMENT FEE	$ 550,541
PHILIP ESFORMES INC. MANAGEMENT FEE	6,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 556,541
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		42,739
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 42,739

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 75,560
Unemployment Compensation Insurance		35,666
FICA Taxes		212,103
Employee Health Insurance		109,176
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		710
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,970
Advertising: Employee Recruitment	1,630
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,722
TRUST/FRANCHISE/CONTRIB/ETC	1,500
LICENSES & PERMITS	1,230
DUES & SUBSCRIPTIONS	9,410
MGMT CO ALLOCATION	1,077
TRUST/FRANCHISE/CONTRIB/ETC	(1,500)
Less: Public Relations Expense	(0)
Non-allowable advertising	(353)
Yellow page advertising	(1,369)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,317

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	2,580
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,580

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT / DECORATING	1997	$ 6,090	3 YRS	$	$	$	$	$	$	$	$	$
2	PAINT / DECORATING	1998	2,585	3 YRS	430								
3	PAINT / DECORATING	1999	2,551	3 YRS	850	426							
4	PAINT / DECORATING	2000	2,926	3 YRS	975	975	488						
5	PAINT / DECORATING	2001	1,458	3 YRS	243	486	486	243					
6	PAINT / DECORATING	2002	1,199	3 YRS		200	400	400	199				
7	PAINT / DECORATING	2003	8,641	3 YRS			1,441	2,880	2,880	1,440			
8	PAINT / DECORATING	2004	3,258	3 YRS				543	1,086	1,086	543		
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 28,708		$ 2,498	$ 2,087	$ 2,815	$ 4,066	$ 4,165	$ 2,526	$ 543	$	$

Facility Name & ID Number BOURBONNAIS TERRACE # 0021550 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $8,776**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **108,154**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees